STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001143	A. BUILDING: _____ B. WING _____	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTAGE MANOR HEALTH CARE FACILITY	3016 PORTAGE AVE SOUTH BEND, IN 46628

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This survey was for a State Residential Licensure Survey. Survey dates: September 23 & 24, 2015 Facility number: 001143 Provider number: 001143 AIM number: N/A Residential census: 121 Residential sample: 7 Portage Manor Health Care Facility was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. QR completed by 14454 on October 27, 2015.	R 000		